Gastroenterology Consultants, PA
History & Physical Questionnaire

Date: ____________________

Name: ____________________ Age: _____ Height: _____ Weight: ________

Family Dr. ____________________ Referred By: ____________________

Reason For Today's Visit: ____________________________________________

Onset of Symptoms: □ Sudden □ Gradual How Long? ____________________

Character of Pain: □ Sharp □ Dull □ Burning □ Aching □ Cramping □ Other ______

Location: □ Epigastric □ Right Lower □ Left Lower □ Right Upper □ Left Upper

Does the pain radiate/move to any other part of the body? □ Yes □ No

If yes, where? ____________________ Frequency: ________ Duration: ______

Does it wake you from sleep? □ Yes □ No Are you under unusual stress? □ Yes □ No

Heartburn? □ Yes □ No If yes, how long? ________ Better with treatment? □ Yes □ No

Medications tried for heartburn/GERD: ______________________________________

Difficulty Swallowing? □ Yes □ No If yes, □ Solids □ Liquids □ Both

Painful Swallowing? □ Yes □ No Appetite: □ Up □ Down □ No change

Weight: □ Up □ Down □ No change Was weight loss intentional? □ Yes □ No □ n/a

Any □ Fever □ Nausea □ Vomiting □ Excessive gas □ Bloating □ Belching

Bowel Movements: □ Regular □ Constipated □ Diarrhea □ Alternating □ Leakage of stool

Frequency of Bowel Movement: ____________________________________________

Any □ Blood □ Mucous □ Dark Black Stools

If there is blood, is blood □ mixed with stool □ on toilet paper only □ both

Was bleeding associated with symptoms of □ dizziness □ passing out □ both

Was blood found on routine examination? □ Yes □ No

Any rectal pain or discomfort? □ Yes □ No

Sometimes unable to make it to the bathroom in time? □ Yes □ No

Bowel Accidents while unaware or while passing gas? □ Yes □ No